CHP+

Child Health Plan *Plus*

FY 2014–2015 Site Review Report Executive Summary

for

Colorado Access CHP+ HMO and State Managed Care Network

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This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

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Introduction

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2014–2015 site review activities for the review period of January 1, 2014, through December 31, 2014, for **Colorado Access** in its role as a contracted health maintenance organization (HMO) and as the State Managed Care Network (SMCN), the administrative service organization (ASO) for the State's CHP+ program. Although **Colorado Access**' CHP+ HMO and the SMCN were reviewed concurrently, results are presented separately within this report. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year for each line of business.[1-1] Section 2 contains graphical representation of results for all standards reviewed over the past three-year cycle and trending of required actions for the CHP+ HMO. Section 3 describes the background and methodology used for the 2014–2015 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2013–2014 site review activities for the CHP+ HMO. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the grievances and appeals record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the CHP+ HMO will be required to complete for FY 2014–2015 and the required template for doing so.

For the SMCN, scores were not assigned; however, findings and recommendations are provided for requirements where the SMCN may not have fully implemented processes to achieve compliance with federal healthcare regulations, or for which opportunities for improvement exist.

[1-1] The Department chose not to score the SMCN this year. HSAG provided findings as evidence of compliance, strengths, and findings resulting in opportunities for improvement; however, the SMCN is not required to complete any required actions.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable* for the CHP+ HMO. HSAG assigned required actions for any requirement receiving a score of *Partially Met* or *Not Met*. Recommendations assigned for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations. HSAG assigned each SMCN requirement a result of *Implemented*, *Partially Implemented*, *Not Implemented*, or *Not Applicable* to provide an assessment of the SMCN's implementation of processes for achieving compliance with federal healthcare regulations.

Table 1-1 presents the scores for **Colorado Access** CHP+ HMO for each of the standards. Findings for all *Met* requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard		# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V	Member Information	23	23	21	2	0	0	91%
VI	Grievance System	26	26	20	6	0	0	77%
VII	Provider Participation and Program Integrity	17	17	17	0	0	0	100%
IX	Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals		**71**	**71**	**63**	**8**	**0**	**0**	**89%**

Table 1-2 presents the scores for **Colorado Access** CHP+ HMO for the grievances and appeals record review. Details of the findings for the record review are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	45	30	23	7	15	77%
Appeals	60	57	43	14	3	75%
Totals	**105**	**87**	**66**	**21**	**18**	**76%**

Standard V—Member Information

The following sections summarize findings applicable to both the CHP+ HMO and the SMCN. Any notable differences in compliance between the CHP+ HMO and the SMCN are identified.

Summary of Strengths and Findings as Evidence of Compliance

The CHP+ HMO and the SMCN member materials, including the Explanation of Coverage (EOC) handbooks, were nearly identical, particularly in the areas related to compliance requirements. Due to the slightly different nature of the two member populations, the SMCN member handbook included additional information related to services for pregnant women. However, there were no notable differences in the CHP+ HMO and SMCN compliance findings related to member information.

The EOCs and other vital member materials were written in easy-to-understand language and were translated into Spanish and available in other languages upon request. Member materials were provided upon enrollment and at other times as required. The member welcome packet included a well-organized booklet that summarized major plan benefits and referred the member to the **Colorado Access** website or customer services for additional information. The website, which allowed members to select translation of online information into more than 50 languages, also provided access to the EOCs, member rights, provider directories, and many other member information resources. Staff provided evidence of extensive internal resources used to support the provision of interpreter services in any language requested by members or providers. Enrollment information notified members that the searchable CHP+ provider directory was available online and that a hard copy could be requested through customer services. The online directory was updated through a real-time interface with the provider database.

Policies and procedures and supporting documentation confirmed that members were notified within the required time frames of any significant changes in information or any provider termination. **Colorado Access** notified parents of CHP+ members annually of their right to request a member handbook, which included member rights and protections. **Colorado Access** did not send an annual letter to SMCN members due to the short enrollment time frame of most members. The EOCs and other member materials included information about covered benefits and applicable copayment amounts, utilization management, grievance and appeal procedures, advance directives, emergency and post-stabilization services, referrals and out-of-network services, enrollment and disenrollment, scheduling guidelines, and other requirements of the contract with the Department.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access should review all required actions outlined for CHP+ HMO and revise SMCN member materials as applicable.

The **Colorado Access** website offered translation into more than 50 different languages. HSAG suggests that **Colorado Access** use this feature to communicate (in the member's translated language) that the member may request translation of any documents or access to interpreter services by calling the customer service number.

Policies and procedures clearly described **Colorado Access**' commitment to inform members of any significant change in member rights or services within 30 days before the change. During on-site interviews, staff members defined "significant change" as pertaining to financial or benefit changes or changes in required time frames. HSAG recommends that **Colorado Access** evaluate its definition of significant change "in information required at 438.10 (f) 6 and (g)" to ensure that it encompasses all information specified in the requirement.

The CHP+ and SMCN EOCs defined post-stabilization services, stated that post-stabilization services were covered, and stated that the member cannot be charged more for out-of-network post-stabilization services than they would be charged if the same services had been provided in-network. However, the EOCs may have incompletely addressed the circumstances for **Colorado Access**' financial responsibility. Therefore, HSAG recommends that **Colorado Access** evaluate its member information related to post-stabilization services and revise them as needed to ensure that members understand that they are never responsible for either prior authorization or payment for post-stabilization services (except for applicable copay amounts).

The CHP+ contract with the Department requires that the member handbook include how the member may request information on **Colorado Access**' healthy living initiative programs. Staff members explained that the equivalent terminology used in the EOCs is "population health outcome" programs. HSAG recommended that **Colorado Access** consider providing a description in the EOCs of the specific prevention or health improvement programs available for members and use terminology that members understand to define "population health outcomes".

Summary of Required Actions (CHP+ HMO only)

Both the CHP+ and SMCN EOCs adequately addressed referral procedures and all copayment amounts as well as other circumstances in which the member may be financially responsible. However, both EOCs erroneously stated that "your PCP may charge you a fee if you do not follow the appointment cancellation policy." Neither federal nor State regulation allow PCPs to charge CHP+ members for missed appointments. **Colorado Access** must remove statements from the CHP+ HMO EOC regarding the potential for members to be charged for missed appointments and ensure that providers do not charge CHP+ members for not following the PCP's appointment cancellation policies.

Both the CHP+ and SMCN EOCs included the statement that enrollment is voluntary, discussed enrollment procedures and how to change PCPs, and accurately listed reasons for termination/disenrollment from the contractor. However, neither the CHP+ nor SMCN EOC described the disenrolled member's right to file a grievance or how to contact the Department concerning disenrollment. In addition, both EOCs (pages 109–110) inaccurately listed "refusal to follow recommended treatment" as a reason **Colorado Access** could terminate coverage. This statement is in conflict with federal member rights standards and is not a reason for "disenrollment for cause" as defined in the CHP+ contract. **Colorado Access** must remove the language concerning "refusal to follow recommended treatment" as a reason for potential termination of coverage. **Colorado Access** must include information in the EOC and related policies to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and inform members about how to access the Department concerning disenrollment.

Standard VI—Grievance System

The following sections summarize findings applicable to both CHP+ and the SMCN. Any notable differences in compliance between CHP+ and the SMCN are identified.

Summary of Strengths and Findings as Evidence of Compliance

Policies, procedures, and processes for managing grievances and appeals applied to both CHP+ and SMCN. Management of both grievances and appeals was conducted by corporate **Colorado Access** staff. Appeals and grievance processes were thoroughly defined in policies and procedures, described in the member handbooks and other member communications, and included in an appeals information attachment sent with notices of action and appeal resolution letters. State fair hearing processes were also thoroughly addressed in policies and member communications. Appeal and grievance decisions were made by persons uninvolved in any previous decision-making and by persons with appropriate clinical expertise, as applicable. Staff members stated that **Colorado Access** contracts with an external medical review vendor to make appeal decisions when an appropriate specialist is unavailable internally. Time frames for filing grievances and appeals were accurately defined and record reviews documented that all grievances and appeals were acknowledged within two days. Member and provider communications included the time frames for filing and processing grievances and appeals. On-site record reviews confirmed that **Colorado Access** resolved all expedited and standard appeals within the required time frames. The grievance and appeal resolution letter templates included a section for results of the resolution process and date resolved. Expedited appeal procedures and the option for members to request continuation of benefits were also adequately described in policies and member communications. Member communications also clearly defined the circumstances in which the member may or may not be responsible to pay for continuation of benefits. CHP+ and SMCN provider manuals included an accurate and thorough description of the grievance system. All appeals and grievances were documented and tracked through the central Altruista information system. **Colorado Access** submitted quarterly reports of all grievances and appeals to the Department, as required.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **Colorado Access** consider the following changes to its appeals policy and procedure (ADM219):

- The policy correctly defined an appeal as a review of an action. In addition, section III, paragraph 2 included a lengthy and somewhat confusing explanation of why "not a covered benefit" is a denial reason that qualifies as an action. Since denial of payment in whole or in part is defined by regulation as an action, HSAG recommends that this paragraph be removed to avoid any potential confusion.
- The policy addressed all required elements of the appeal process defined in 10 CCR2505-10, Section 8.209.4. G and H (requirement #15 on tool) with the exception of "oral inquiries seeking to appeal are treated as appeals to establish the earliest possible filing date." On-site interviews confirmed that **Colorado Access** was accurately applying this requirement in its appeal processes. HSAG recommended that it also be added to the policy.

Policy ADM203 (Grievance Process) adequately defined the disposition time frames for grievances and stated that "in most cases" a written resolution notice is sent to the member. Staff members stated that "in most cases" refers to the time frames and not the written resolution. Since all grievances require a written notice of disposition, HSAG recommends that **Colorado Access** clarify the language in the policy accordingly.

Colorado Access applied a 14-day extension to 78 percent of the grievances records reviewed on-site. HSAG observed that this was an unusually high proportion of cases requiring extensions and recommended that **Colorado Access** evaluate the reasons for extensions to ensure that grievances are being resolved as expeditiously as possible and that extensions are being used appropriately, as defined in 10 CCR 2505-10, Section 8.209.

The Appeal Rights Attachment to the member notices of action described that the member or his or her designated client representative (DCR) may present information pertaining to an appeal as defined in the requirement (Requirement # 15). However, the attachment did not inform the member of the right to examine the member's case file and did not inform the member of the limited time to present information in expedited appeals. The CHP+ and SMCN EOCs included a description of all elements in the requirement. HSAG recommends that **Colorado Access** consider adding information to the Appeal Rights Attachment or reference the member EOC in the attachment in order to provide the member with complete information on the appeals process.

HSAG recommends that, when an appeal is related to denial of payment, **Colorado Access** consider adding a statement in the Appeal Upheld letter (and possibly the original notice of action) to inform the member that he or she is not financially responsible for payment. As regulations do not permit members to be billed for services, HSAG suggests that such a statement may prevent the member from initiating unnecessary appeals or requests for State fair hearings.

Colorado Access policies, CHP+ and SMCN provider manuals, and CHP+ and SMCN EOCs defined "grievance" according to the requirement. However, the grievance record review included six records that were member requests for reimbursement of out-of-pocket expenses. A member request for reimbursement is not an "expression of dissatisfaction" and, therefore, is not a grievance. (These records were omitted from the record review sample.) Staff members explained that these requests are processed and tracked through the grievance department to ensure timely response to the member. However, HSAG recommends that **Colorado Access** ensure that the grievance tracking system accurately designate "grievance" as a member complaint or "expression of dissatisfaction" in accordance with federal and State definitions.

HSAG makes the following recommendations specific to SMCN:

- **Colorado Access** should review all required actions outlined for CHP+ HMO and revise SMCN member and provider communications, as applicable.
- The SMCN Appeal Upheld letter stated that the member may contact the Health Care Policy & Financing (HCPF) contract manager if dissatisfied with the results. This is inaccurate. The member's only option after denial of an appeal is the State fair hearing. HSAG recommended that **Colorado Access** remove this statement from the SMCN appeal upheld letter.
- The SMCN EOC stated that, if **Colorado Access** denies a request for an expedited appeal, **Colorado Access** will notify the member in writing in two business days. Per requirement, the

member must be notified in two calendar days. HSAG recommends that **Colorado Access** revise the SMCN EOC to accurately state two calendar days rather than two business days.

Summary of Required Actions (CHP+ HMO only)

Colorado Access policies, CHP+ and SMCN provider manuals, and CHP+ and SMCN EOCs accurately defined a grievance according to the requirement. However, the grievance record review included six records that were member requests for reimbursement of out-of-pocket expenses. (These records were omitted from the record review sample.) A member request for reimbursement is not an "expression of dissatisfaction" and, therefore, not a grievance. **Colorado Access** should revise internal procedures to ensure that the grievance tracking system accurately designates "grievance" as a member complaint or "expression of dissatisfaction" about any matter other than an action.

Colorado Access policies, CHP+ and SMCN provider manuals, and CHP+ and SMCN EOCs informed members and providers that grievances would be resolved within 15 days of receipt of the grievance (unless an extension was filed), and stated that the member would receive a letter explaining the resolution of the grievance and the date completed. The grievance resolution letter template included a section for results of the resolution process and the date resolved. On-site grievance record reviews documented that seven of nine (78 percent) records included an extension and five of nine cases (56 percent) were resolved within the required time frame of 15 working days plus 14 calendar days (as applicable). The remaining four of the nine records were not resolved within the required time frame because **Colorado Access** closed the grievance before it was resolved. Three of these four cases included a letter to the member informing them the case was being closed due to expiration of the allowed time frame. The letter assured the member that **Colorado Access** would continue working to resolve the matter, but did not include documentation of any follow-up correspondence regarding ultimate resolution of the grievance. One case provided a written status report to the member, and was recorded as "closed" in the tracking system. In this case, there was a follow-up letter to the member regarding the ultimate resolution, but the case was not resolved in the required time frame. As the grievances were closed before being resolved, three of the nine cases did not meet the resolution portion of the "resolved within allowable time frames" criteria and the fourth case did not meet the required time frame portion of the criteria. In addition, these cases did not meet the criteria for required content of the resolution letter (i.e., result of resolution or date resolved). **Colorado Access** must:

- Implement mechanisms to complete the resolution of grievances, whether or not the time frame has expired.
- Revise member resolution letters to include an appropriate explanation of the disposition of the grievance. (Letters informing members that a case is being closed because the time frame has expired are not resolutions.) Resolution letters must include a description of the *results* of the resolution process and the date the grievance was *resolved.*
- Ensure that it resolves grievances within the required time frame, unless it is clearly in the member's best interest to extend the time frame for resolution.

The appeals policy (ADM219) accurately stated that members may file an appeal within 30 calendar days from the date of the notice of action. However, the State fair hearing section of the

appeals policy stated that, "Except for actions that involve the suspension, termination, or reduction of services, members may request a State fair hearing…within 30 calendar days of the NOA." The CHP+ and SMCN EOCs and the appeal rights attachment (included with the CHP+ and SMCN notice of action) included the stipulation that, if the member is appealing a reduction/suspension of existing services, the member must appeal within 10 days of the notice of action. The CHP+ and SMCN EOCs and the CHP+ and SMCN provider manuals similarly stated that the member must request a State fair hearing within 10 calendar days for actions that involve suspension, termination, or reduction of services. The reduced 10-day time frame for filing an appeal or requesting a State fair hearing applies only when the member is requesting continuation of benefits during an appeal or State fair hearing. **Colorado Access** must correct policies and procedures and related CHP+ member and provider communications to accurately describe:

- That a member may file an appeal or request a State fair hearing for any action (including suspension, termination, or reduction of services) within 30 calendar days from the date of the notice of action, unless the member is requesting continuation of previously authorized services during the appeal or State fair hearing process.
- That the 10-day requirement for filing an appeal or requesting a State fair hearing applies only when the member is requesting continuation of benefits pending the outcome of an appeal or State fair hearing.

Member communications concerning the member's right to a State fair hearing included several inaccuracies:

- The SMCN and CHP+ appeal upheld letters stated, "If you are not satisfied with this decision, you may appeal." Seventy percent of the appeal resolution letters reviewed on site informed the member that if he or she was not satisfied with the outcome of the appeal, he or she could file an appeal. The Appeal Upheld resolution letter should reference the member's right to a State fair hearing, not an appeal.
- The CHP+ and SMCN member EOCs stated, "If you are not happy with the outcome of the expedited or rushed appeal, you have the right to file a grievance." The member may file a grievance when dissatisfied with the denial of a request for an expedited appeal, not when dissatisfied with the outcome of the appeal. The member has the right to request a State fair hearing, not a grievance, if the appeal resolution is not wholly in the member's favor.

Colorado Access must revise inaccuracies in member communications, including the Appeal Upheld letter and CHP+ EOC, to clarify that the member has a right to request a State fair hearing if not satisfied with the outcome of the appeal.

Seven of the ten appeal resolution letters in the on-site record review were written in difficult-to-understand language, resulting in a 30 percent compliance score with this element. The appeal review results included in the Appeal Upheld letter appeared to incorporate the medical reviewer's findings verbatim and often contained medical jargon. Per the requirement 42CFR438.10 (b)(1),(d), that all vital member communications be written in easy-to-understand language, **Colorado Access** must develop a mechanism to ensure that appeal resolution letters are written in language that is easy for members to understand.

Standard VII—Provider Participation and Program Integrity

The following sections summarize findings applicable to both the CHP+ and the SMCN. Any notable differences in compliance between the CHP+ and the SMCN are identified.

Summary of Strengths and Findings as Evidence of Compliance

All policies, procedures, and processes related to the requirements for Provider Participation and Program Integrity applied to all **Colorado Access** lines of business. All elements in this Standard have been implemented for CHP+ and SMCN.

Policies and procedures documented that **Colorado Access** has a thorough process for credentialing and recredentialing of providers in compliance with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Committee (URAC) standards. Policies also specified methods for precredentialing and monthly monitoring for provider sanctions against applicable federal and state databases, monitoring for grievances and other quality of care actions against providers, annual on-site audit of medical record standards for a rotating sample of high-volume providers, quarterly surveys to monitor access to care standards, and profiling of utilization patterns and CHP+ Healthcare Effectiveness Data and Information Set (HEDIS®)[1-2] measures. Staff stated that the CHP+ and SMCN provider networks were nearly identical, so provider monitoring activities were applicable to both contracts. All findings were reported to senior management committees and the Quality Improvement Committee (QIC), as evidenced in on-site review of QIC meeting minutes. Results were considered in the recredentialing process, as appropriate, and provider corrective action plans were developed to address identified deficiencies. Policies and procedures stated that **Colorado Access** does not discriminate against providers and does not restrict providers from acting on behalf of their patients. **Colorado Access** notified providers of reasons for declining participation in the network, which staff stated is generally due to analysis of network sufficiency for the number or types of providers needed to serve the members.

The **Colorado Access** Professional Provider Agreement (applicable to all lines of business) included the requirements that providers comply with **Colorado Access**' Utilization Management and Quality Improvement programs. The provider agreement and provider manual stated that providers may not, for any reason, bill or charge members, and members were encouraged to call **Colorado Access** to report any billing complaints. Member EOCs communicated that **Colorado Access** does not hold moral or religious beliefs affecting the provision of services, and providers were required to report to **Colorado Access** any provider-specific conscientious objections to provision of member services.

Numerous corporate policies and procedures, the Corporate Compliance Plan, and the Medicaid Compliance Plan (applicable to CHP+) documented robust and well-established procedures to guard against fraud, waste, and abuse (FWA) and to maintain all corporate compliance standards. All adverse outcomes related to sanction screenings, suspected FWA, quality of care concerns, and HIPAA violations were reported to the Department. Staff described internal processes (including suspension of provider payments and contract termination) that could be implemented as a result of any identified suspicion of provider fraud.

[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Advance directives policies, applicable to adult members of the CHP+ and SMCN programs, as well as provider and member communications documented that **Colorado Access** had addressed all applicable advance directives requirements outlined in federal regulations. During the on-site review, **Colorado Access** added to its website a link to the Colorado State law concerning advance directives.

Summary of Findings Resulting in Opportunities for Improvement

The Professional Provider Agreement described broad contract requirements, but did not specify many provider rules and responsibilities detailed in the provider manual. HSAG recommends that, if **Colorado Access** expects its providers to contractually comply with the procedures outlined in the provider manual, it should explicitly reference the CHP+ and SMCN provider manuals in the Professional Provider Agreement.

Colorado Access identified several mechanisms for ongoing monitoring of CHP+ providers for select contract requirements and quality improvement activities, including an on-site monitoring tool for medical records requirements and a provider profile report focused on utilization trends. HSAG recommends that **Colorado Access** consider enhancing the on-site audit tools to incorporate other contract compliance elements, such as compliance with credentialing standards, advance directives, and scheduling guidelines. Additionally, HSAG recommends that **Colorado Access** consider adding more quality elements to the provider profile report and sharing the provider profile report with the individual providers for review and feedback.

Summary of Required Actions (CHP+ HMO only)

There were no required actions for this Standard.

Standard IX—Subcontracts and Delegation

The following sections summarize findings applicable to both the CHP+ and the SMCN. Any notable differences in compliance between the CHP+ and the SMCN are identified.

Summary of Strengths and Findings as Evidence of Compliance

All policies, procedures, and processes related to the requirements for Subcontracts and Delegation applied to all **Colorado Access** lines of business and were corporately driven. All elements in this Standard have been implemented for CHP+ and SMCN. CHP+ delegated credentialing, claims processing, and other select administrative responsibilities to subcontractors. Policies and written agreements with delegates documented that **Colorado Access** retains ultimate responsibility for delegated functions. Pre-delegation assessment of a prospective delegate's capabilities included extensive desk review and on-site audit of policies, procedures, and adequacy of staff to perform the delegated activities. **Colorado Access** performed a comprehensive annual audit of its delegates and performed ongoing monitoring through periodic reports submitted by those delegates. Any deficiencies identified in pre-delegation or ongoing audits required a corrective action plan, with re-audit every three months until action plans were completed. Delegation agreements described the delegated responsibilities in detail, periodic reporting responsibilities of the delegate, annual audit by **Colorado Access** with corrective action plans to remedy any deficiencies, and **Colorado Access**' ability to revoke delegated functions or the entire delegation agreement based on inadequate performance. **Colorado Access** maintained documentation of both audit findings and any required follow-up in a comprehensive database, the Compliance 360 system. All delegation assessment results and ongoing monitoring activities were reported to the Delegation Oversight Committee (DOC), as evidenced in the DOC meeting minutes.

During on-site discussions, staff members demonstrated audit results documented and tracked in the Compliance 360 system and discussed examples of action plans, including one which required weekly on-site meetings between **Colorado Access** compliance staff and delegates to remedy deficiencies. Staff members stated that action plans are initiated regularly to correct gaps in performance and audits have, on occasion, resulted in revocation of delegated functions or delegate status.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access' processes related to delegation of CHP+ contract responsibilities were comprehensive and actively implemented. HSAG identified no additional opportunities for improvement.

Summary of Required Actions (CHP+ HMO only)

There were no required actions for this Standard.